BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **KYLA KYM MCMILLAN, AKA** **KYLA KYM SCOTT** **11248 Crazy Horse Drive** **Lakeside, CA 92040** **Registered Nurse License No. 641771** Respondent.	Case No. 2012-642 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about April 17, 2012, Complainant Louise R. Bailey, M.Ed., RN, in her official capacity as the Interim Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs, filed Accusation No. 2012-642 against Kyla Kym McMillan, also known as Kyla Kym Scott (Respondent) before the Board. (The Accusation is attached as Exhibit A.)

2. On or about July 28, 2004, the Board issued Registered Nurse License No. 641771 to Respondent. The Registered Nurse License was in full force and effect at all times relevant to the charges brought in Accusation No. 2012-642, and expired on May 31, 2012, unless renewed. This lapse in licensure, however, pursuant to Business and Professions Code section 118(b) and/or Business and Professions Code section 2764 does not deprive the Board of its authority to institute or continue this disciplinary proceeding.

3. On or about April 17, 2012, Respondent was served by Certified and First Class Mail copies of the Accusation No. 2012-642, Statement to Respondent, Notice of Defense, Request for

Discovery, and Discovery Statutes (Government Code sections 11507.5, 11507.6, and 11507.7) at Respondent's address of record which, pursuant to California Code of Regulations, title 16, section 1409.1, is required to be reported and maintained with the Board. Respondent's address of record was and is: 11248 Crazy Horse Drive, Lakeside, CA 92040.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c) and/or Business & Professions Code section 124.

5. On or about May 8, 2012, the aforementioned documents were returned by the U.S. Postal Service marked "Unclaimed."

6. Government Code section 11506 states, in pertinent part:

> (c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

7. Respondent failed to file a Notice of Defense within 15 days after service upon her of the Accusation, and therefore waived her right to a hearing on the merits of Accusation No. 2012-642.

8. California Government Code section 11520 states, in pertinent part:

> (a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

9. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on the relevant evidence contained in the Default Decision Evidence Packet in this matter, as well as taking official notice of all the investigatory reports, exhibits and statements contained therein on file at the Board's offices regarding the allegations contained in Accusation No. 2012-642, finds that the charges and allegations in Accusation No. 2012-642, are separately and severally, found to be true and correct by clear and convincing evidence.

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10. Taking official notice of its own internal records, pursuant to Business and Professions Code section 125.3, it is hereby determined that the reasonable costs for Investigation and Enforcement is $30,068.50.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Kyla Kym McMillan, also known as Kyla Kym Scott has subjected her Registered Nurse License No. 641771 to discipline.

2. The agency has jurisdiction to adjudicate this case by default.

3. The Board of Registered Nursing is authorized to revoke Respondent's Registered Nurse License based upon the following violations alleged in the Accusation which are supported by the evidence contained in the Default Decision Evidence Packet in this case:

a. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by 2762, subdivision (a), and in violation of Code section 4060 and Health and Safety Code section 11173, subdivision (a), in that on at least 25 occasions in and between February 2010 and March 2010, Respondent diverted controlled substances, including: morphine; Hydrocodone; Temazepam; and Oxycodone from the hospital inventory while employed and on duty as a registered nurse in the Critical Care and Intensive Care Units at Sharp Coronado Hospital in San Diego, California;

b. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by 2762, subdivision (e), in that Respondent made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital records pertaining to these controlled substances;

c. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (f), 2762, subdivisions (b) and (c), and section 490 in that on May 6, 2010, Respondent was convicted by her plea of guilty to violating Health and Safety Code section 11377, subdivision (a), possession of a controlled substance, PCP, a felony; and

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ORDER

IT IS SO ORDERED that Registered Nurse License No. 641771 issued to Respondent Kyla Kym McMillan, also known as Kyla Kym Scott, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on OCTOBER 11, 2012.

It is so ORDERED SEPTEMBER 11, 2012

Raymond Mallel

FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

70577998.DOC
DOJ Matter ID:SD201070295

Attachment:
Exhibit A: Accusation

d. Respondent is also subject to disciplinary action pursuant to Code section 2761, subdivision (f), and section 490 in that on May 6, 2010, Respondent was convicted by her plea of guilty to violating Vehicle Code section 12500, subdivision (a), driving on a suspended license, a misdemeanor.

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Exhibit A

Accusation

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **KYLA KYM MCMILLAN,** **AKA KYLA KYM SCOTT** **11248 Crazy Horse Drive** **Lakeside, CA 92040** **Registered Nurse License No. 641771** Respondent.	Case No. 2012-642 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about July 28, 2004, the Board issued Registered Nurse License Number 641771 to Kyla Kym McMillan, also known as Kyla Kym Scott (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2012, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 2811(b) of the Code provides, in pertinent part, that each license not renewed shall expire but may within a period of eight years thereafter be reinstated upon payment of the biennial renewal fee and penalty fee and upon submission of such proof of the applicant's qualifications as may be required by the board, except that during such eight-year period no examination shall be required as a condition for the reinstatement of any such expired license which has lapsed solely by reason of non-payment of the renewal fee.

STATUTORY AUTHORITIES

7. Code section 490 states:

"(a) In addition to any other action that a board is permitted to take against a licensee, a board may suspend or revoke a license on the ground that the licensee has been convicted of a crime, if the crime is substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued.

"(b) Notwithstanding any other provision of law, a board may exercise any authority to discipline a licensee for conviction of a crime that is independent of the authority granted under subdivision (a) only if the crime is substantially related to the qualifications, functions, or duties of the business or profession for which the licensee's license was issued.

"(c) A conviction within the meaning of this section means a plea or verdict of guilty or a conviction following a plea of nolo contendere. An action that a board is permitted to take

following the establishment of a conviction may be taken when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code."

8. Code section 492 states in relevant part:

"Notwithstanding any other provision of law, successful completion of any diversion program under the Penal Code, or successful completion of an alcohol and drug problem assessment program under Article 5 (commencing with Section 23249.50) of Chapter 12 of Division 11 of the Vehicle Code, shall not prohibit any agency established under Division 2 (commencing with Section 500) of this code, or any initiative act referred to in that division, from taking disciplinary action against a licensee or from denying a license for professional misconduct, notwithstanding that evidence of that misconduct may be recorded in a record pertaining to an arrest.

". . . ."

9. Code section 2761 states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse . . . for any of the following:

"(a) Unprofessional conduct . . .

". . . .

"(f) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof.

". . . ."

10. Code section 2762 states in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter it is unprofessional conduct for a person licensed under this chapter to do any of the following:

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"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

"(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

"(c) Be convicted of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in subdivisions (a) and (b) of this section, or the possession of, or falsification of a record pertaining to, the substances described in subdivision (a) of this section, in which event the record of the conviction is conclusive evidence thereof.

". . . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

11. Code section 4060 states in relevant part:

"No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052. This section shall not apply to the possession of any controlled substance by a manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse-

midwife, nurse practitioner, or physician assistant, when in stock in containers correctly labeled with the name and address of the supplier or producer.

"Nothing in this section authorizes a certified nurse-midwife, a nurse practitioner, a physician assistant, or a naturopathic doctor, to order his or her own stock of dangerous drugs and devices.

12. Health and Safety Code section 11173 states in pertinent part:

"(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

". . . ."

REGULATIONS

13. California Code of Regulations, title 16, section 1444 provides:

"A conviction or act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare. Such convictions or acts shall include but not be limited to the following:

"(a) Assaultive or abusive conduct including, but not limited to, those violations listed in subdivision (d) of Penal Code Section 11160.

"(b) Failure to comply with any mandatory reporting requirements.

"(c) Theft, dishonesty, fraud, or deceit.

"(d) Any conviction or act subject to an order of registration pursuant to Section 290 of the Penal Code."

14. California Code of Regulations, title 16, section 1444.5 provides:

"In reaching a decision on a disciplinary action under the Administrative Procedure Act (Government Code Section 11400 et seq.), the Board shall consider the disciplinary guidelines entitled: "Recommended Guidelines for Disciplinary Orders and Conditions of Probation" (10/02) which are hereby incorporated by reference. Deviation from these guidelines and orders, including the standard terms of probation, is appropriate where the board in its sole discretion

determines that the facts of the particular case warrant such a deviation -for example: the presence of mitigating factors; the age of the case; evidentiary problems."

15. California Code of Regulations, title 16, section 1445 provides, in relevant part:

". . . .

"(b) When considering the suspension or revocation of a license on the grounds that a registered nurse has been convicted of a crime, the board, in evaluating the rehabilitation of such person and his/her eligibility for a license will consider the following criteria:

"(1) Nature and severity of the act(s) or offense(s).

"(2) Total criminal record.

"(3) The time that has elapsed since commission of the act(s) or offense(s).

"(4) Whether the licensee has complied with any terms of parole, probation, restitution or any other sanctions lawfully imposed against the licensee.

"(5) If applicable, evidence of expungement proceedings pursuant to Section 1203.4 of the Penal Code.

"(6) Evidence, if any, of rehabilitation submitted by the licensee."

COST RECOVERY

16. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

17. Hydrocodone is a Schedule II controlled substance as designated by Health and Safety Code Section 11055, and is a dangerous drug pursuant to Business and Professions Code section 4022. Hydrocodone is used to control moderate pain.

18. Morphine is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1), and is a dangerous drug pursuant to Business and Professions Code section 4022. Morphine is used to control moderate to severe pain.

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19. Oxycodone, also sold under the brand name OxyContin, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1), and is a dangerous drug pursuant to Business and Professions Code section 4022. Oxycodone is used to control moderate to severe pain.

20. Phencyclidine, also known as PCP or "angel dust," is a Schedule II controlled substance as designated by Health and Safety Code section 11055(e)(3)(A), and is a dangerous drug pursuant to Business & Professions Code section 4022.

21. Restoril, a brand name for temazepam, is a Schedule IV controlled substance as designated by Health and Safety Code Section 11057(d)(29), and is a dangerous drug pursuant to Business and Professions Code section 4022. Restoril is a central nervous depressant used to treat insomnia and sleep disorders.

FACTS

22. In and between February 2010 and March 2010, while employed and on duty as a registered nurse in the Critical Care and Intensive Care Units at Sharp Coronado Hospital in San Diego, California, Respondent diverted controlled substances from the hospital inventory, and incorrectly charted the administration of medications in hospital records as follows:

Patient No. 1 (PR 70300742)

23. This patient had physician's orders for Oxycodone 10 m.g., every 12 hours for 48 hours. On or about March 11, 2010, Respondent withdrew two 5/325 mg tablets of Oxycodone from the Pyxis[1] for Patient No. 1 at 2050, charted in the Medication Administration Record and Nursing Notes that she administered one 5/325 mg tablet of Oxycodone to Patient No. 1 at 2045, but failed to chart the wastage of or otherwise account for the disposition of the remaining one

[1] Pyxis" is a trade name for the automatic single-unit dose medication dispensing system that records information such as patient name, physician orders, date and time medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. Each user/operator is given a user identification code to operate the control panel. Sometimes only portions of the withdrawn narcotics are given to the patient. The portions not given to the patient are referred to as "wastage." This waste must be witnessed by another authorized user and is also recorded by the Pyxis machine.

5/325 mg tablet of Oxycodone. Therefore, Respondent failed to account for one tablet of 5/325 mg Oxycodone that she withdrew in the name of Patient No. 1.

Patient No. 2 (PR 70302311)

24. This patient had physician's orders for Morphine 1 m.g., as needed for pain. In summary, between March 3, 2010 and March 12, 2010, Respondent removed 56 mg of Morphine from the Pyxis for Patient No. 2, charted in the Medication Administration Record and Nursing Notes that she administered 27 mg of Morphine to Patient No. 2, and wasted 21 mg of Morphine. Respondent administered the Morphine when the patient did not request it, and when there was no indication in the pain assessment record that the patient needed it as the doctor's order required. Furthermore, the other registered nurses caring for Patient No. 2 did not administer any Morphine to Patient No. 2 on either the prior or successive shifts. Respondent failed to account for 8 mg of Morphine that she withdrew in the name of Patient No. 2, as follows:

25. On or about March 3, 2010, Respondent withdrew two 2 mg syringes of Morphine from the Pyxis for Patient No. 2 at 2345, charted in the Medication Administration Record and Nursing Notes that she administered 3 mgs Morphine to Patient No. 2 at 2330, but failed to chart the wastage of or otherwise account for the disposition of the remaining one mg of Morphine. Therefore, Respondent failed to account for 1 mg of Morphine.

26. On or about March 4, 2010, Respondent withdrew one 10 mg syringe of Morphine from the Pyxis for Patient No. 2 at 0231, charted in the Medication Administration Record and Nursing Notes that she administered 3 mgs Morphine to Patient No. 2 at 0230, and wasted the remaining 7 mg of Morphine.

27. On or about March 4, 2010, Respondent withdrew two 2 mg syringes of Morphine from the Pyxis for Patient No. 2 at 2145, charted in the Medication Administration Record and Nursing Notes that she administered 3 mgs Morphine to Patient No. 2 at 2100, but failed to chart the wastage of or otherwise account for the disposition of the remaining one mg of Morphine. Therefore, Respondent failed to account for 1 mg of Morphine.

28. On or about March 4, 2010, Respondent withdrew one 10 mg syringe of Morphine from the Pyxis for Patient No. 2 at 2358, charted in the Medication Administration Record and

Nursing Notes that she administered 3 mgs Morphine to Patient No. 2 on March 5, 2010 at 0030, and wasted the remaining 7 mg of Morphine.

29. On or about March 5, 2010, Respondent withdrew one 10 mg syringe of Morphine from the Pyxis for Patient No. 2 at 0344, charted in the Medication Administration Record and Nursing Notes that she administered 3 mgs Morphine to Patient No. 2 at 0330, and wasted the remaining 7 mg of Morphine.

30. On or about March 5, 2010, Respondent withdrew one 2 mg syringe of Morphine from the Pyxis for Patient No. 2 at 0652, failed to chart in the Medication Administration Record and Nursing Notes that she administered any of the Morphine to Patient No. 2, and failed to chart the wastage of or otherwise account for the disposition of the 2 mg of Morphine. Therefore, Respondent failed to account for 2 mg of Morphine.

31. On or about March 11, 2010, Respondent withdrew two 2 mg syringes of Morphine from the Pyxis for Patient No. 2 at 2119, charted in the Medication Administration Record and Nursing Notes that she administered 4 mgs Morphine to Patient No. 2 at 2120.

32. On or about March 12, 2010, Respondent withdrew two 2 mg syringes of Morphine from the Pyxis for Patient No. 2 at 0117, charted in the Medication Administration Record and Nursing Notes that she administered 4 mgs Morphine to Patient No. 2 at 0115.

33. On or about March 12, 2010, Respondent withdrew two 2 mg syringes of Morphine from the Pyxis for Patient No. 2 at 0341, charted in the Medication Administration Record and Nursing Notes that she administered 4 mgs of Morphine to Patient No. 2 at 0330.

34. On or about March 12, 2010, Respondent withdrew two 2 mg syringes of Morphine from the Pyxis for Patient No. 2 at 0612, failed to chart in the Medication Administration Record and Nursing Notes that she administered any of the Morphine to Patient No. 2, and failed to chart the wastage of or otherwise account for the disposition of four mg of Morphine. Therefore, Respondent failed to account for 4 mg of Morphine.

Patient No. 3 (PR70300021)

35. This patient had physician's orders for Morphine 2 m.g. as needed for pain, and one 10 m.g. tablet of Hydrocodone for pain. In summary, between February 20, 2010 and February

21, 2010, Respondent charted in the Medication Administration Record and Nursing Notes that she administered Morphine to Patient No. 3 four hours after she removed it from the Pyxis on one occasion, and four hours before she removed it from the Pyxis on another occastion. Respondent also failed to account for 20 mg of Hydrocodone that she withdrew in the name of Patient No. 3 as follows:

36. On or about February 20, 2010, Respondent withdrew two 2 mg syringes of Morphine from the Pyxis for Patient No. 3 at 2052, yet charted in the Medication Administration Record and Nursing Notes that on February 21, 2010, she administered the 4 mg of Morphine to Patient No. 3 at 0001, four hours after Respondent removed the Morphine from the Pyxis.

37. On or about February 21, 2010, Respondent withdrew two 2 mg syringes of Morphine from the Pyxis for Patient No. 3 at 0808, yet charted in the Medication Administration Record and Nursing Notes that she administered the 4 mg of Morphine to Patient No. 3 at 0400, four hours before Respondent removed the Morphine from the Pyxis.

38. On or about February 20, 2010, Respondent withdrew one 10 mg tablet of Hydrocodone from the Pyxis for Patient No. 3 at 2144, and charted in the Medication Administration Record and Nursing Notes that she administered the one 10 mg tablet of Hydrocodone to Patient No. 3 at 2100, 44 minutes before she withdrew the Hydrocodone from the Pyxis.

39. On or about February 21, 2010, Respondent withdrew one 10 mg Hydrocodone tablet from the Pyxis for Patient No. 3 at 0207, and charted in the Medication Administration Record and Nursing Notes that she administered the one 10 mg Hydrocodone tablet to Patient No. 3 at 0200, 7 minutes before she withdrew the Hydrocodone from the Pyxis.

40. On or about February 21, 2010, Respondent withdrew one 10 mg Hydrocodone tablet from the Pyxis for Patient No. 3 at 0315, failed to chart in the Medication Administration Record and Nursing Notes that she administered the Hydrocodone tablet to Patient No. 3, and failed to chart the wastage of or otherwise account for the disposition of the 10 mg Hydrocodone tablet. Therefore, Respondent failed to account for 10 mg of Hydrocodone.

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41. On or about February 21, 2010, Respondent withdrew one 10 mg Hydrocodone tablet from the Pyxis for Patient No. 3 at 0553, failed to chart in the Medication Administration Record and Nursing Notes that she administered the Hydrocodone tablet to Patient No. 3, and failed to chart the wastage of or otherwise account for the disposition of the 10 mg Hydrocodone tablet. Therefore, Respondent failed to account for 10 mg of Hydrocodone.

Patient No. 4 (PR70297359)

42. In summary, between February 19, 2010 and February 21, 2010, Respondent withdrew five 10 mg Hydrocodone tablets, and one 15 mg capsule of Temazepam for Patient No. 4 when this person was not an inpatient at the hospital on these dates. Respondent failed to account for 50 mg of Hydrocodone, and 15 mg of Temazepam that she withdrew in the name of Patient No. 4, as follows:

43. On or about February 19, 2010, Respondent withdrew one 10 mg Hydrocodone tablet from the Pyxis for Patient No. 4 at 0038. Patient No. 4 was not an inpatient on this date. Therefore, Respondent failed to account for 10 mg of Hydrocodone.

44. On or about February 19, 2010, Respondent withdrew one 10 mg Hydrocodone tablet from the Pyxis for Patient No. 4 at 0337. Patient No. 4 was not an inpatient on this date. Therefore, Respondent failed to account for 10 mg of Hydrocodone.

45. On or about February 20, 2010, Respondent withdrew one 10 mg Hydrocodone tablet from the Pyxis for Patient No. 4 at 2058. Patient No. 4 was not an inpatient on this date. Therefore, Respondent failed to account for 10 mg of Hydrocodone.

46. On or about February 21, 2010, Respondent withdrew one 10 mg Hydrocodone tablet from the Pyxis for Patient No. 4 at 0004. Patient No. 4 was not an inpatient on this date. Therefore, Respondent failed to account for 10 mg of Hydrocodone.

47. On or about February 21, 2010, Respondent withdrew one 10 mg Hydrocodone tablet from the Pyxis for Patient No. 4 at 0317. Patient No. 4 was not an inpatient on this date. Therefore, Respondent failed to account for 10 mg of Hydrocodone.

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48. On or about February 20, 2010, Respondent withdrew one 15 mg Temazepam capsule from the Pyxis for Patient No. 4 at 2058. Patient No. 4 was not an inpatient on this date. Therefore, Respondent failed to account for 15 mg of Temazepam.

Patient No. 5 (PR70299939)

49. This patient had physician's orders for Morphine 2 m.g. as needed for pain. In summary, between February 20, 2010 and February 21, 2010, Respondent removed 12 mg of Morphine from the Pyxis for Patient No. 5, charted in the Medication Administration Record and Nursing Notes that she administered only 4 mg of Morphine to Patient No. 5. Respondent failed to account for 8 mg of Morphine that she withdrew in the name of Patient No. 5, as follows:

50. On February 21, 2010, Respondent withdrew two 2 mg Morphine syringes from the Pyxis for Patient No. 5 at 0139, and charted in the Medication Administration Record and Nursing Notes that she administered 4 mg the Morphine to Patient No. 5 at 0001/0100, thirty-nine minutes before Respondent withdrew the Morphine from the Pyxis.

51. On or about February 21, 2010, Respondent withdrew two 2 mg Morphine syringes from the Pyxis for Patient No. 5 at 0317, failed to chart in the Medication Administration Record and Nursing Notes that she administered any of the Morphine to Patient No. 5, and failed to chart the wastage of or otherwise account for the disposition of the 4 mg of Morphine. Thereofore, Respondent failed to account for 4 mg of Morphine.

52. On or about February 21, 2010, Respondent withdrew two 2 mg Morphine syringes from the Pyxis for Patient No. 5 at 0649, failed to chart in the Medication Administration Record and Nursing Notes that she administered any of the Morphine to Patient No. 5, and failed to chart the wastage of or otherwise account for the disposition of the 4 mg of Morphine. Thereofore, Respondent failed to account for 4 mg of Morphine.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Diversion of Controlled Substances)

53. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by 2762, subdivision (a), and in violation of Code section 4060 and Health and Safety Code section 11173, subdivision (a),

in that Respondent diverted controlled substances from the hospital inventory as set forth in paragraphs 22 though 52, which are incorporated here by this reference.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Grossly Inconsistent Charting)

54. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by 2762, subdivision (e), in that Respondent made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital records pertaining to controlled substances as set forth in paragraphs 22 through 52, which are incorporated here by this reference.

THIRD CAUSE FOR DISCIPLINE

(May 6, 2010 Conviction for Possession of PCP on February 28, 2010)

55. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (f), 2762, subdivisions (b) and (c), and section 490 in that Respondent was convicted of a crime substantially related to the qualifications, functions, or duties of a registered nurse. The circumstances are as follows:

56. a. On May 6, 2010, in a criminal case entitled *The People of the State of California v. Kyla Kym McMillan*, San Diego County Superior Court case number CD226001, Respondent was convicted by her plea of guilty to violating Health and Safety Code section 11377, subdivision (a), possession of a controlled substance, PCP, a felony.

b. The facts that led to this conviction are that on February 28, 2010, at 9:53 p.m. a California Highway Patrol (CHP) officer responded to a radio call from CHP dispatch advising that a red Ford Taurus was stopped in the #4 lane of I-15 northbound, north of SR-163 in San Diego. Upon his arrival to the location, the officer did not locate any such vehicle. CHP dispatch then advised the CHP officer that a second motorist reported that the Ford Taurus was now moving northbound on I-15 at a slow rate of speed. The officer proceeded northbound on I-15 in a distinctly marked black and white CHP patrol vehicle while wearing a full CHP uniform. He observed several vehicles braking and merging around a very slow moving red Ford Taurus traveling in the #4 lane. The officer positioned his patrol vehicle to the rear of the red Ford

Taurus, and greatly reduced his speed to match the speed of the Taurus. The officer noted that the speedometer of the patrol vehicle recorded that they were traveling at a speed of 20 mph. The officer also noted as he followed the Taurus that it was not staying in a single lane of travel. The officer activated his full code-three red and blue lights and siren. The driver of the Taurus did not respond to the lights and siren. The officer then began to give the driver instructions over the public address (PA) system to merge to the right. The driver, later identified as Respondent, did not respond to the PA commands even though the left front driver's window was more than half way down and the CHP patrol vehicle was approximately 30 feet to the left rear of Respondent's Taurus. As they approached the Scripps Poway Parkway exit, the CHP officer observed that Respondent continued to drive at speeds ranging from 20-35 mph. Respondent did not exit the interstate. Another CHP unit responded to a request for assistance. For the safety of the motoring public, the second CHP unit ran a traffic break behind the first CHP officer, who was still following Respondent. The first CHP officer continued to follow Respondent. As he did so, the CHP officer noted that Respondent maintained a fixed stare straight ahead, and never gave any acknowledgement that she was being pulled over. Respondent, with the CHP officer following her, drove past the Poway Road exit. Additional units arrived behind the first CHP officer as Respondent approached the Ted Williams Parkway exit. Respondent did exit the I-15 at the Ted Williams Parkway exit. However, despite the officer's instructions to exit the off-ramp, Respondent came to an abrupt stop on the Ted Williams Parkway off-ramp prior to reaching the intersection. The first responding CHP officer positioned his patrol vehicle to the left rear of the Taurus, and the second responding CHP officers used their vehicle to box the Taurus in front to prevent Respondent from accelerating. When the CHP officer approached Respondent sitting in the Taurus he noticed that she maintained a fixed stare straight ahead, and slowly complied with his commands to keep her hands on the steering wheel. The officer instructed Respondent to exit the vehicle. The officer noticed that Respondent's eyes were glassy and red. When Respondent exited her vehicle, and staggered around and would not comply with the officer's instructions. Her speech was mumbled, and incoherent. Based on the CHP officer's observations, and Respondent's signs of drug impairment, he arrested her. Following the arrest, the CHP officer

requested a license check, and CHP dispatch confirmed that Respondent's driver's license was suspended. While Respondent's purse was prepared for booking, the CHP officer discovered vials of the following medications inside it: Ondansetron, Famotidine, Rantidine (150 mg), Tramadol HCL (50 mg), Hydrochlorothiazide (25 mg), Alprazolam (25 mg), and Enalapril (5 mg). While preparing Respondent's vehicle for storage, another CHP officer discovered the following empty medication vials inside it: one vial labeled Hydrocodone, dated June 11, 2009; one vial labeled Hydrocodone dated February 10, 2010 - 18 days prior to the arrest - with 70 tablets, 1 tablet to be taken 3 times daily; and one vial labeled Hydrocodone dated February 3, 2010 – 25 days prior to the arrest – with 60 tablets, 1 tablet to be taken once daily.

c. As a result of her conviction for possession of a controlled substance, PCP, Respondent was ordered to attend a drug rehabilitation program for a period of 18 months under Penal Code section 1000 beginning June 7, 2010, and to pay a DEA administration fee of $150.00.

FOURTH CAUSE FOR DISCIPLINE

(May 6, 2010 Criminal Conviction for Driving on a Suspended License on April 6, 2010)

57. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (f), and section 490 in that Respondent was convicted of a crime substantially related to the qualifications, functions, or duties of a registered nurse. The circumstances are as follows:

58. a. On May 6, 2010, in a criminal case entitled *The People of the State of California v. Kyla Kym McMillan*, San Diego County Superior Court case number M105255, Respondent was convicted by her plea of guilty to violating Vehicle Code section 12500, subdivision (a), driving on a suspended license, a misdemeanor.

b. The facts that led to this conviction are that on April 6, 2010, while traveling east on 1500 J Street in San Diego, San Diego police officers noticed a burgundy Ford Taurus stopped in the westbound lane of J Street just east of 16th Street. The vehicle was stopped in such a way that the front of the vehicle was facing northeast, blocking the westbound traffic. There were three vehicles waiting behind this Ford. As one of these vehicles tried to drive go around the Ford, the driver of the Ford proceeded to back up, almost striking that vehicle. The Ford then proceeded

forward, and made a northbound turn onto 16th Street from J Street. The officers checked the Ford's license plate using their in-car computer, and confirmed that the license plate was expired. The San Diego police officers followed the Ford. It continued on 16th street, and made a westbound trun onto 1500 Island Avenue and stopped. The officers approached the vehicle and asked the female driver for her license. The female, later identified as Respondent, pointed to the passenger and said, "He is driving so, he can show you his license." The officer told Respondent that he saw her driving and needed to see her license. Respondent told the officers that the passenger had her license. The officer told her to get the license and give it to him. The passenger said that he did not have Respondent's license. Respondent then told the officer that the passenger left her license at home. Respondent gave the officer her sister's name and date of birth. The officers later discovered Respondent's true identity, and confirmed that her California driver's license was suspended.

c. As a result of her conviction, Respondent was ordered to not drive without a valid driver license and liability insurance, and to pay a fine of $500.00 with a credit of $500.00 for 10 days served.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Registered Nurse License Number 641771 issued to Kyla Kym McMillan, also known as Kyla Kym Scott;

2. Ordering Kyla Kym McMillan to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: April 17, 2012

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant